Complete Summary

GUIDELINE TITLE

Antithrombotic therapy in peripheral arterial occlusive disease: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy.

BIBLIOGRAPHIC SOURCE(S)

Clagett GP, Sobel M, Jackson MR, Lip GY, Tangelder M, Verhaeghe R. Antithrombotic therapy in peripheral arterial occlusive disease: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest 2004 Sep;126(3 Suppl):609S-26S. [154 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Jackson MR, Clagett GP. Antithrombotic therapy in peripheral arterial occlusive disease. Chest 2001 Jan;119(1 Suppl):283S-299S.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Peripheral arterial occlusive disease (PAOD), including:

- Chronic limb ischemia
- Acute limb ischemia

GUIDELINE CATEGORY

Treatment

CLINICAL SPECIALTY

Cardiology
Emergency Medicine
Family Practice
Internal Medicine
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence-based recommendations on the use of antithrombotic therapy in patients with peripheral arterial occlusive disease (PAOD)

TARGET POPULATION

- Patients with acute or chronic peripheral arterial occlusive disease (PAOD)
- Patients requiring vascular grafts
- Patients requiring carotid endarterectomy
- Patients undergoing lower extremity balloon angioplasty with or without stenting

INTERVENTIONS AND PRACTICES CONSIDERED

Antithrombotic Pharmacologic Treatment in Chronic Limb Ischemia

1. Aspirin therapy alone
2. Aspirin therapy in combination with dipyridamole
3. Clopidogrel
4. Cilostazol

Note: Other agents that were considered for the treatment of intermittent claudication, but not recommended, included: pentoxifylline, prostaglandins, ticlopidine, ketanserin, suloctidil, fish oil supplementation, and naftidrofuryl. Anticoagulants also are not recommended for intermittent claudication.

Antithrombotic Pharmacologic Treatment in Acute Limb Ischemia

1. Heparin therapy (unfractionated heparin [UFH])
2. Vitamin K antagonist (VKA)
3. Intra-arterial thrombolytic therapy

Antithrombotic Pharmacologic Treatment in Peripheral Vascular Reconstructive Surgery

1. UFH
2. Aspirin therapy

3. VKA plus aspirin (recommended only in patients at high risk of bypass occlusion and limb loss)

Note: Other agents were considered, but not recommended, including ticlopidine and clopidogrel.

Antithrombotic Pharmacologic Treatment in Carotid Endarterectomy

1. Aspirin therapy

Antithrombotic Pharmacologic Treatment in Asymptomatic and Recurrent Carotid Stenosis

1. Aspirin therapy

Antithrombotic Pharmacologic Treatment in Lower Extremity Endovascular Procedures

1. Aspirin therapy

MAJOR OUTCOMES CONSIDERED

Effectiveness and safety of treatment as evidenced by the following:

- Rates of vascular mortality
- Rates of surgical intervention required for treatment
- Rates of morbidity related to complications of peripheral vascular disease, such as nonfatal stroke, myocardial infarction, and limb amputation
- Patency of vein grafts following peripheral vascular reconstructive surgery

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Process of Searching for Evidence

Defining the clinical question provided the framework for formulating eligibility criteria that guided the search for relevant evidence. Prior to searching for the evidence, methodological experts and librarians reviewed each question to ensure that the librarians could derive a comprehensive search strategy.

In specifying eligibility criteria, authors not only identified patients, interventions, and outcomes, but also methodological criteria. For most therapeutic studies, authors restricted eligibility to randomized controlled trials (RCTs).

For many questions, RCTs did not provide sufficient data, and article authors also included observational studies. This was also true when randomized trials were not the most appropriate design to use for addressing the research question. In particular, randomized trials are not necessarily the best design to understand risk groups (e.g., the baseline or expected risk of a given event for certain subpopulations). Because there are no interventions examined in questions about prognosis, one replaces interventions by the exposure, which is time.

Identifying the Evidence

To identify the relevant evidence, a team of librarians at the University at Buffalo conducted comprehensive literature searches. For each question the authors provided, the librarians developed sensitive (but not specific) search strategies, including all languages, and conducted separate searches for systematic reviews, RCTs, and, if applicable, observational studies. The librarians searched the Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effectiveness and Cochrane Register of Controlled Trial, the ACP Journal Club, MEDLINE, and Embase for studies published between 1966 and June 2002 in any language. To filter MEDLINE and Embase search results for RCT evidence, the librarians used the search strategy developed by the Cochrane Collaboration (full strategy available in Appendix online at: http://www.chestjournal.org/content/vol126/3_suppl_1).

For observational studies, they restricted their searches to human studies. Searches were not further restricted in terms of methodology. While increasing the probability of identifying all published studies, this sensitive approach resulted in large number of citations for many of the defined clinical questions. Therefore, trained research assistants screened the citation list developed from the search and removed any apparently irrelevant citations. These irrelevant citations included press news, editorials, narrative reviews, single case reports, animal studies (any nonhuman studies), and letters to the editor. Authors included data from abstracts of recent meetings if reporting was transparent and all necessary data for the formulation of a recommendation were available. The guideline developers did not explicitly use Internet sources to search for research data.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The rating scheme framework captures the trade-off between benefits and risks (1 or 2) (and the methodological quality of the underlying evidence (A, B, C+, or C). See "Rating Scheme for the Strength of the Recommendations."

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Summarizing Evidence

The electronic searches also included searching for systematic reviews. If authors were satisfied with a recent high-quality systematic review, evidence from that review provided a foundation for the relevant recommendation.

Pooled analyses from high-quality systematic reviews formed, wherever possible, the evidence base of the recommendations. Pooling offers the advantage of obtaining more precise estimates of treatment effects and allows for a greater generalizability of results. However, pooling also bears the risk of spurious generalization. In general, the summary estimates of interest were the different types of outcomes conveying benefit and downsides (i.e., risk, burden, and cost).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Consensus Development Conference)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The strength of any recommendation depends on the following two factors: the trade-off between the benefits and the risks, burdens, and costs; and the strength of the methodology that leads to the treatment effect. The guideline developers grade the trade-off between benefits and risks in the two categories: 1, in which the trade-off is clear enough that most patients, despite differences in values, would make the same choice; and 2, in which the trade-off is less clear, and individual patients´ values will likely lead to different choices.

When randomized trials provide precise estimates suggesting large treatment effects, and the risks and costs of therapy are small, treatment for average patients with compatible values and preferences can be confidently recommended.

If the balance between benefits and risks is in doubt, methodologically rigorous studies providing Grade A evidence and recommendations may still be weak (Grade 2). Uncertainty may come from less precise estimates of benefit, harm, or costs, or from small effect sizes.

There is an independent impact of validity and consistency, and the balance of positive and negative impacts of treatment on the strength of recommendations. In situations in which there is doubt about the value of the trade-off, any recommendation will be weaker, moving from Grade 1 to Grade 2.

Grade 1 recommendations can only be made when there is a relatively clear picture of both the benefits and the risks, burdens, and costs, and when the balance between the two clearly favors recommending or not recommending the

intervention for the typical patient with compatible values and preferences. A number of factors can reduce the strength of a recommendation, moving it from Grade 1 to Grade 2. Uncertainty about a recommendation to treat may be introduced if the following conditions apply: (1) the target event that is trying to be prevented is less important (confident recommendations are more likely to be made to prevent death or stroke than asymptomatic deep vein thrombosis); (2) the magnitude of risk reduction in the overall group is small; (3) the probability of the target event is low in a particular subgroup of patients; (4) the estimate of the treatment effect is imprecise, as reflected in a wide confidence interval (CI) around the effect; (5) there is substantial potential harm associated with therapy; or (6) there is an expectation for a wide divergence in values even among average or typical patients. Higher costs would also lead to weaker recommendations to treat.

The more balanced the trade-off between benefits and risks, the greater the influence of individual patient values in decision making. Virtually all patients, if they understand the benefits and risks, will take aspirin after experiencing a myocardial infarction (MI) or will comply with prophylaxis to reduce the risk of thromboembolism after undergoing hip replacement. Thus, one way of thinking about a Grade 1 recommendation is that variability in patient values is unlikely to influence treatment choice in average or typical patients.

When the trade-off between benefits and risks is less clear, individual patient values may influence treatment decisions even among patients with average or typical preferences.

Grade 2 recommendations are those in which variation in patient values or individual physician values will often mandate different treatment choices, even among average or typical patients. An alternative, but similar, interpretation is that a Grade 2 recommendation suggests that clinicians conduct detailed conversations with patients to ensure that their ultimate recommendation is consistent with the patient's values.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grade of Recommendation	Clarity of Risk/Benefit	Methodological Strength of Supporting Evidence	Implications
1A	Clear	Randomized controlled trials (RCTs) without important limitations	Strong recommendation; can apply to most patients in most circumstances without reservation
1C+	Clear	No RCTs, but strong RCT	Strong recommendation;

Grade of Recommendation	Clarity of Risk/Benefit	Methodological Strength of Supporting Evidence	Implications
		results can be unequivocally extrapolated, or overwhelming evidence from observational studies	can apply to most patients in most circumstances
1B	Clear	RCTs with important limitations (inconsistent results, methodological flaws*)	Strong recommendation; likely to apply to most patients
1C	Clear	Observational studies	Intermediate-strength recommendation; may change when stronger evidence is available
2A	Unclear	RCTs without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances or patients' or societal values
2C+	Unclear	No RCTs, but strong RCT results can be unequivocally extrapolated, or overwhelming evidence from observational studies	Weak recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	RCTs with important limitations	Weak recommendation; alternative

Grade of Recommendation	Clarity of Risk/Benefit	Methodological Strength of Supporting Evidence	Implications
		(inconsistent results, methodological flaws*)	approaches likely to be better for some patients under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; other alternatives may be equally reasonable

*These situations include RCTs with both lack of blinding and subjective outcomes, where the risk of bias in measurement of outcomes is high, or RCTs with large loss to follow-up.

COST ANALYSIS

While conference participants agreed that recommendations should reflect economic considerations, incorporating costs is fraught with difficult challenges. For most recommendations, formal economic analyses are unavailable. Even when analyses are available, they may be methodologically weak or biased. Furthermore, costs differ radically across jurisdictions, and even sometimes across hospitals within jurisdictions.

Because of these challenges, the guideline developers consider economic factors only when the costs of one therapeutic option over another are substantially different within major jurisdictions in which clinicians make use of these recommendations. As a result, in jurisdictions in which resource constraints are severe, alternative allocations may serve the health of the public far better than some of the interventions that are designated as Grade 1A. This will likely be true for all less industrialized countries and, with the increasing promotion of expensive drugs with marginal benefits, may be increasingly true for wealthier nations. Furthermore, recommendations change (either in direction or with respect to grade) only when the guideline developers believe that costs are high in relation to benefits. Instances in which costs have influenced recommendations are labeled in the "values and preferences" statements associated with the recommendation.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline authors formulated draft recommendations prior to the conference that served as the foundation for authors to work together and critique the recommendations. Drafts of all articles including draft recommendations were available for review during the conference. A representative of each article presented potentially controversial issues in their recommendations at plenary meetings. Article authors met to integrate feedback, to consider related recommendations in other articles, and to revise their own guidelines accordingly. Authors continued this process after the conference until they reached agreement within their groups and with other author groups who had provided critical feedback. Finally, the editors of this supplement harmonized the articles and resolved remaining disagreements through facilitated discussion.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The rating scheme is defined at the end of the "Major Recommendations" field.

Chronic Limb Ischemia

Antiplatelet Therapy

Aspirin

1. The guideline developers recommend lifelong aspirin therapy, 75 to 325 mg/day, in comparison to no antiplatelet therapy in patients with clinically manifest coronary or cerebrovascular disease (Grade 1A) and in those without clinically manifest coronary or cerebrovascular disease (Grade 1C+)

Ticlopidine

1. The guideline developers recommend clopidogrel over ticlopidine (Grade 1C+).

Clopidogrel

1. The guideline developers recommend clopidogrel in comparison to no antiplatelet therapy (Grade 1C+), but suggest that aspirin be used instead of clopidogrel (Grade 2A).

   Underlying values and preferences: This recommendation places a relatively high value on avoiding large expenditures to achieve small reductions in vascular events.

Cilostazol

1. For patients with disabling intermittent claudication who do not respond to conservative measures (risk factor modification and exercise therapy) and who are not candidates for surgical or catheter-based intervention, the guideline developers suggest cilostazol (Grade 2A). The guideline developers

suggest that clinicians not use cilostazol in those with less-disabling claudication (Grade 2A).

Underlying values and preferences: The recommendation against cilostazol for those with less-disabling claudication places a relatively low value on small possible improvements in function in the absence of clear improvement in health-related quality of life.

Pentoxifylline

1. The guideline developer recommend against the use of pentoxifylline (Grade 1B).

Prostaglandins

1. For limb ischemia, the guideline developers suggest clinicians not use prostaglandins (Grade 2B).

   Underlying values and preferences: The recommendation places a low value on achieving small gains in walking distance in the absence of demonstrated improvement in quality of life.

Other Agents

1. In patients with intermittent claudication, the guideline developers recommend against the use of anticoagulants (Grade 1A).

Acute Limb Ischemia

Heparin

1. In patients with acute arterial emboli or thrombosis, the guideline developers recommend treatment with immediate systemic anticoagulation with unfractionated heparin (UFH) to prevent thrombotic propagation (Grade 1C). The guideline developers also recommend systemic anticoagulation with UFH followed by long-term vitamin K antagonist (VKA) to prevent recurrent embolism in patients undergoing embolectomy (Grade 1C).

Thrombolysis

1. In patients with short-term (<14 days) thrombotic or embolic disease with low risk of myonecrosis and ischemic nerve damage developing during the time to achieve revascularization by this method, the guideline developers suggest intra-arterial thrombolytic therapy (Grade 2B).

   Underlying values and preferences: This recommendation places relatively little value on small reductions in the need for surgical intervention and relatively high value on avoiding large expenditures and possible major hemorrhagic complications.

Vascular Grafts

Intraoperative Anticoagulation during Vascular Reconstruction

1. For patients undergoing major vascular reconstructive procedures, the guideline developers recommend UFH at the time of application of vascular cross-clamps (Grade 1A).

Prolonging the Patency of Grafts

Antiplatelet Agents

1. In patients undergoing prosthetic infrainguinal bypass, the guideline developers recommend aspirin (Grade 1A).

Vitamin K Antagonists (VKAs)

1. The guideline developers suggest that VKA not be used routinely in patients undergoing infrainguinal femoropopliteal or distal vein bypass (Grade 2A).

   Underlying values and preferences: This recommendation attributes relatively little value to small increases in long-term patency and relatively high value to avoiding hemorrhagic complications.

VKA Plus Aspirin

1. For routine patients undergoing infrainguinal bypass without special risk factors for occlusion, the guideline developers recommend against VKA plus aspirin (Grade 1A). For those at high risk of bypass occlusion and limb loss, the guideline developers suggest VKA plus aspirin (Grade 2B).

   Underlying values and preferences: These recommendations place high value on the avoidance of bleeding complications but recognize that there are circumstances where the threat of limb loss and major disability may supercede the risk.

Carotid Endarterectomy

Aspirin

1. The guideline developers recommend that aspirin, 75 to 325 mg/day, be given preoperatively and continued indefinitely in patients undergoing carotid endarterectomy (Grade 1A).

Asymptomatic and Recurrent Carotid Stenosis

1. In nonoperative patients with asymptomatic or recurrent carotid stenosis, the guideline developers recommend lifelong aspirin, 75 to 162 mg/day (Grade 1C+).

Lower Extremity Endovascular Procedures

1. For all patients undergoing lower-extremity balloon angioplasty (with or without stenting), the guideline developers recommend long-term aspirin, 75 to 162 mg/day (Grade 1C+).

Definitions

Grade of Recommendation	Clarity of Risk/Benefit	Methodological Strength of Supporting Evidence	Implications
1A	Clear	Randomized controlled trials (RCTs) without important limitations	Strong recommendation; can apply to most patients in most circumstances without reservation
1C+	Clear	No RCTs, but strong RCT results can be unequivocally extrapolated, or overwhelming evidence from observational studies	Strong recommendation; can apply to most patients in most circumstances
1B	Clear	RCTs with important limitations (inconsistent results, methodological flaws*)	Strong recommendation; likely to apply to most patients
1C	Clear	Observational studies	Intermediate-strength recommendation; may change when stronger evidence is available
2A	Unclear	RCTs without important limitations	Intermediate-strength recommendation; best action may differ depending on circumstances

Grade of Recommendation	Clarity of Risk/Benefit	Methodological Strength of Supporting Evidence	Implications
			or patients' or societal values
2C+	Unclear	No RCTs, but strong RCT results can be unequivocally extrapolated, or overwhelming evidence from observational studies	Weak recommendation; best action may differ depending on circumstances or patients' or societal values
2B	Unclear	RCTs with important limitations (inconsistent results, methodological flaws*)	Weak recommendation; alternative approaches likely to be better for some patients under some circumstances
2C	Unclear	Observational studies	Very weak recommendation; other alternatives may be equally reasonable

*These situations include RCTs with both lack of blinding and subjective outcomes, where the risk of bias in measurement of outcomes is high, or RCTs with large loss to follow-up.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Antiplatelet therapy may modify the natural history of chronic lower-extremity arterial insufficiency, as well as lower the incidence of associated cardiovascular events.
- A compelling reason to administer antiplatelet therapy to patients with peripheral arterial occlusive disease (PAOD) is to prevent death and disability from stroke and myocardial infarction (MI).

POTENTIAL HARMS

- There are risks for adverse events from antithrombotic therapy, particularly bleeding.
- The expected adverse effect of perioperative anticoagulant therapy is an increased risk of wound complications, particularly hematomas.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Interpreting the Recommendations

Clinicians, third-party payers, institutional review committees, or the courts should not construe these guidelines in any way as absolute dictates. In general, anything other than a Grade 1A recommendation indicates that the article authors acknowledge that other interpretations of the evidence, and other clinical policies, may be reasonable and appropriate. Even Grade 1A recommendations will not apply to all circumstances and all patients. For instance, the guideline developers have been conservative in their considerations of cost and have seldom downgraded recommendations from Grade 1 to Grade 2 on the basis of expense. As a result, in jurisdictions in which resource constraints are severe, alternative allocations may serve the health of the public far better than some of the interventions that are designated as Grade 1A. This will likely be true for all less industrialized countries and, with the increasing promotion of expensive drugs with marginal benefits, may be increasingly true for wealthier nations.

Similarly, following Grade 1A recommendations will at times not serve the best interests of patients with atypical values or preferences or of those whose risks differ markedly from those of the usual patient. For instance, consider patients who find anticoagulant therapy extremely aversive, either because it interferes with their lifestyle (e.g., prevents participation in contact sports) or because of the need for monitoring. Clinicians may reasonably conclude that following some Grade 1A recommendations for anticoagulation therapy for either group of patients will be a mistake. The same may be true for patients with particular comorbidities (e.g., a recent gastrointestinal bleed or a balance disorder with repeated falls) or other special circumstances (e.g., very advanced age) that put them at unusual risk.

The guideline developers trust that these observations convey their acknowledgment that no recommendations or clinical practice guidelines can take into account the often compelling and unique features of individual clinical circumstances. No clinician, and no body charged with evaluating a clinician´s actions, should attempt to apply these recommendations in a rote or blanket fashion.

Limitations of Guideline Development Methods

The limitations of these guidelines include the possibility that some authors followed this methodology more closely than others, although the development process was centralized and supervised by the editors. Second, it is possible that the guideline developers missed relevant studies despite the comprehensive searching process. Third, the guideline developers did not centralize the methodological evaluation of all studies to facilitate uniformity in the validity assessments of the research incorporated into these guidelines. Fourth, if high-quality meta-analyses were unavailable, the guideline developers did not statistically pool primary study results using meta-analysis. Finally, sparse data on patient preferences and values, resources, and other costs represent additional limitations that are inherent to most guideline development methods.

Limitations of Antithrombotic Therapy in Peripheral Arterial Occlusive Disease

This guideline addresses antithrombotic therapy for patients with peripheral arterial occlusive disease (PAOD). The guideline developers note, however, that a systematic review and meta-analysis of randomized trials of exercise therapy in patients with claudication suggests that exercise improves maximal walking time by 150%. One must judge symptomatic antithrombotic therapy in this context. Furthermore, while risk factor modification is not well studied in patients with peripheral arterial occlusive disease, observational data and generalization from trials in persons with other manifestations of cardiovascular disease support the importance of treating key risk factors such as smoking, diabetes, dyslipidemia, and hypertension.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Guideline Implementation Strategies

A full review of implementation strategies for practice guidelines is provided in the companion document titled "Antithrombotic and Antithrombolytic Therapy: From Evidence to Application." The review suggests that there are few implementation strategies that are of unequivocal, consistent benefit, and that are clearly and consistently worth resource investment. The following is a summary of the recommendations (see "Major Recommendations" for a definition of the recommendation grades).

To encourage uptake of guidelines, the guideline developers recommend that appreciable resources be devoted to distribution of educational material (Grade 2B).

They also suggest that:

- Few resources be devoted to educational meetings (Grade 2B)
- Few resources be devoted to educational outreach visits (Grade 2A)
- Appreciable resources be devoted to computer reminders (Grade 2A)
- Appreciable resources be devoted to patient-mediated interventions to encourage uptake of the guidelines (Grade 2B)
- Few resources be devoted to audit and feedback (Grade 2B)

IMPLEMENTATION TOOLS

Patient Resources
Personal Digital Assistant (PDA) Downloads
Quick Reference Guides/Physician Guides
Resources
Slide Presentation
Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Clagett GP, Sobel M, Jackson MR, Lip GY, Tangelder M, Verhaeghe R. Antithrombotic therapy in peripheral arterial occlusive disease: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Chest 2004 Sep;126(3 Suppl):609S-26S. [154 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Jan (revised 2004 Sep)

GUIDELINE DEVELOPER(S)

American College of Chest Physicians - Medical Specialty Society

SOURCE(S) OF FUNDING

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American College of Chest Physicians Consensus Panel on Antithrombotic and Thrombolytic Therapy

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Dr. Sobel has received research funding from Commonwealth Biotechnologies Inc, and has received no honoraria or consulting fees from pharmaceutical or technology firms.

Dr. Jackson has not received industry funding for research and has not received honoraria during this time period.

Dr. Lip has received research funding from AstraZeneca, Merck, and Servier, and has received honoraria for his participation on advisory boards and/or as a speaker at educational events from AstraZeneca, Servier, Boehringer Ingelheim, Novartis, Mitsubishi, Pharma, Yamanuchi, Bristol-Myers Squibb, Sanofi-Synthelabo-Organon, GlaxoSmithKline, Sankyo and Merck.

Dr. Tangelder is at present an employee of Sanofi-Synthelabo. During the preparation of the text for this guideline, he had nothing to declare.

Dr. Verhaeghe has received research support from AstraZeneca AB and Sanofi-Organon.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Jackson MR, Clagett GP. Antithrombotic therapy in peripheral arterial occlusive disease. Chest 2001 Jan;119(1 Suppl):283S-299S.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Chest - The Cardiopulmonary and Critical Care Journal.

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Evidence-based guidelines. Northbrook, IL: ACCP, 2004 Sep.

- Methodology for guideline development for the Seventh American College of Chest Physicians Conference on Antithrombotic and Thrombolytic Therapy. Northbrook, IL: ACCP, 2004 Sep.
- Applying the grades of recommendation for antithrombotic and thrombolytic therapy: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Northbrook, IL: ACCP, 2004 Sep.
- Hemorrhagic complications of anticoagulant treatment: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Northbrook, IL: ACCP, 2004 Sep.
- Antithrombotic and thrombolytic therapy: from evidence to application: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Northbrook, IL: ACCP, 2004 Sep.
- Platelet-active drugs: the relationships among dose, effectiveness, and side effects: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy. Northbrook, IL: ACCP, 2004 Sep.

Electronic copies: Available from the Chest - The Cardiopulmonary and Critical Care Journal Web site.

Print copies: Available from the American College of Chest Physicians (ACCP), Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

The following is also available:

- Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy: Evidence-based guidelines; quick reference guide. Northbrook, IL: ACCP, 2004 Sep. Personal Digital Assistant (PDA) download available at ACCP Web site.

Additional implementation tools are also available:

- Clinical resource: antithrombotic and thrombolytic therapy. Northbrook, IL. ACCP, 2004. Ordering information: Available from the ACCP Web site.

PATIENT RESOURCES

The following is available:

- A patient's guide to antithrombotic and thrombolytic therapy. In: Clinical resource: antithrombotic and thrombolytic therapy. Northbrook (IL): American College of Chest Physicians (ACCP). 2004.

Ordering information is available from the ACCP Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the

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NGC STATUS

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